

9695

## CERTIFICATE OF DEATH

Reg. Dist. No. 09702

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> OR <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> OR <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Maryland Hospital</u>	STREET ADDRESS (If rural give location) <u>Hughlett</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Nancy Ellen Willey Abbott</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>12</u> <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>April 25, 1885</u>
9. AGE last birthday: <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Shirt Factory</u>	
11. BIRTHPLACE (State or foreign country): <u>Lakesville, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Willey</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah E. Wroten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not KNOWN</u>	
17. INFORMANT & ADDRESS: <u>Cambridge, Md.</u> <u>Mrs. Charles Whaples, Hughlett St.,</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			<u>10 minutes</u>
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis Generalized</u>			<u>5 yrs +</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			<u>5 yrs +</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hemiplegia; Rt.</u>			<u>24 hrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-28</u> , 19 <u>55</u> , to <u>10-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>55</u> , and that death occurred at <u>12:50 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Eldridge H. Poyle</u>		ADDRESS <u>Cambridge Md.</u> DATE SIGNED <u>10-14-55</u>	
M. D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/15/55.</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 15 1955</u>		REGISTRAR'S SIGNATURE <u>John P. O.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Le Compte Funeral Service, Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 20 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9775

## CERTIFICATE OF DEATH

Reg. Dist. No. 178

09703

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Dorchester</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Cambridge</i>	LENGTH OF STAY (in this place) <i>11 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>American Corners</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Eastern Shore State Hospital</i>	STREET ADDRESS (If rural give location) <i>05X-2</i>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <i>Frederick Herman Beauchamp</i>		OF DEATH: <i>10 - 8 19 55</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>5-17-1875</i>
9. AGE last birthday <i>80</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Farm Owner</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>William Beauchamp</i>		14. MOTHER'S MAIDEN NAME: <i>Belie Sullivan</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS: <i>Eastern Shore State Hospital records.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>420.0 Arteriosclerotic Heart Disease</i>			<i>1 yr +</i>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Generalized Arteriosclerosis</i>			<i>10 yr +</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>9-27-1955</i> to <i>10-8, 1955</i> that I last saw the deceased alive on <i>10-8, 1955</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>George S. Currier</i>		DATE SIGNED <i>10-8-55</i>	
ADDRESS <i>Cambridge, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>October 12 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		LOCATION (City, town, or county) (State) <i>Federalburg, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Oct. 12, 1955</i>		REGISTRAR'S SIGNATURE <i>John H. Racy, M.D.</i>	
24. FUNERAL DIRECTOR <i>J. J. Frampton &amp; Son, Federalburg, Md.</i>		ADDRESS	

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OCT 13 1955

BUREAU V. S.

OCT 13 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9636

09704  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>1 month</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bishops Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Perry</u>		(Middle) <u>Wesley</u>		(Last) <u>Bramble</u>		(Month) (Day) (Year) <u>Oct. 31, 1955</u> 19	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Feb. 2, 1871</u>	
9. AGE last birthday: <u>84</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Waterman self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Bishops Head</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>George D. Bramble</u>			
14. MOTHER'S MAIDEN NAME: <u>Mary E. Moore</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u> <u>no</u>			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>Mrs. J. Naamon Mills, Bishops Head, Md.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO <u>704.0</u> stating underlying cause last (c)						<u>5 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>34 days</u>	
<u>Fracture Left Femur</u>						<u>34 days</u>	
19a. DATE OF OPERATION: <u>10/4/55</u>				19b. MAJOR FINDING OF OPERATION: <u>Hip Pinning</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>				21c. (City or town) (County) (State) <u>Bishops Head Dorchester Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9/27/55 9 A. M.</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21f. HOW DID INJURY OCCUR? <u>Fell in his home.</u>				22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John Moore</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Nov. 2 '55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>Nov. 2, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Robinson Family Cemetery</u> LOCATION (City, town, or county) (State) <u>Bishops Head, Md.</u>			
DATE REC'D BY LOCAL REG. <u>Nov. 1, 1955</u>				REGISTRAR'S SIGNATURE <u>John D. Hall</u> 24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u> ADDRESS			

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BUREAU V. S.

NOV 4 1955

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9706

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09705  
Reg. Dist.

No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:									
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>							
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)									
<input checked="" type="checkbox"/> TOWN <u>Hurlock—Rural</u>		<u>10 yrs.</u>		TOWN <u>Hurlock—Rural</u>									
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hurlock, Md. R. F. D.</u>				STREET ADDRESS <u>Hurlock, Md. R. F. D.</u> (If rural, give location)									
3. NAME OF DECEASED: (First) <u>Cecil</u>		(Middle)		(Last) <u>Crawford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>October 17 1955</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 10, 1901</u>		9. AGE last birthday: <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>IF UNDER 1 YEAR</td><td>IF UNDER 24 HRS.</td></tr><tr><td>Months</td><td>Days</td></tr><tr><td><u>4</u></td><td><u>7</u></td></tr></table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	<u>4</u>	<u>7</u>
IF UNDER 1 YEAR	IF UNDER 24 HRS.												
Months	Days												
<u>4</u>	<u>7</u>												
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Canning Factory—Phillips Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>						
13. FATHER'S NAME: <u>Daniel C Crawford</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Judie</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>217-14-8067</u>		17. INFORMANT & ADDRESS: <u>Mrs. Cecil Crawford, Hurlock, Md. R. F. D.</u>									
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>						
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:													
<p><u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO</p> <p>Antecedent cause(s) (b) _____ DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____</p>													
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.													
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) _____ (County) _____		21d. (State) _____							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?									
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
SIGNATURE <u>John M. [Signature]</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/17/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>									
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hurlock, Md.</u>							
DATE REC'D BY LOCAL REG. <u>Oct 22-1955</u>		REGISTRAR'S SIGNATURE <u>Charles Hastings</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS							

BUREAU V. 2

NOV 4 1955

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

VS A15 (4)  
15M 9/55



DUPLICATE COPY

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>R.F.D. # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>DAIL</u> Last <u>DAIL</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 7, 1889</u>		9. AGE (In years lost birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>R.F.D. Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Dail</u>				14. MOTHER'S MAIDEN NAME <u>Mary I. Keyes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Elizabeth E. Dail Cambridge, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma</u> <u>177x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of prostate</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>30 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <u>10</u> Day <u>13</u> Year <u>1955</u> Hour <u>4:10</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>52</u> , to <u>10/3</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>10/3</u> , 19 <u>55</u> , and that death occurred at <u>4:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u>		M.D. <u>Cambridge, Md.</u>		ADDRESS (Street, city or town, state) <u>Locust Street Cambridge, Maryland</u>		DATE SIGNED <u>5/19/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William H. Hanks</u>		M.D. <u>M.D.</u>		ADDRESS <u>Locust Street Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/55</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Seward-Dail Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D. # 3 Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>May 21, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. Hanks</u>			

MEDICAL CERTIFICATION

**BUREAU V. S.**

MAY 23 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09707

9707

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>rural Cambridge</u>		LENGTH OF STAY (in this place) <u>1 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge, Md.</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WADE</u> <u>HAMPTON</u> <u>FALLIN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 11</u> <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>single</u>	8. DATE OF BIRTH: <u>2/21/81</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>watchman</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Christopher Fallin</u>				14. MOTHER'S MAIDEN NAME: <u>Augie Edgar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>							
(A) <u>General arteriosclerosis</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral arteriosclerosis</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 8, 1955 to Oct. 11, 1955 that I last saw the deceased alive on Oct. 11, 1955, and that death occurred at 9:37 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>[Signature]</u>		<u>[Address]</u>		<u>10/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/11/55</u>		<u>Thurgate</u>		<u>Thurgate Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 13, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Address]</u>	

RECEIVED

OCT 14 1955

BUREAU V. 2

9738

99708  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Cambridge</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS <u>-</u> (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Emma</u>	(Middle) <u>-</u>	(Last) <u>Gibbons</u>	(Month) <u>Oct.</u> (Day) <u>1</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Jan. 13, 1886</u>
9. AGE last birthday: <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William J. Gibbons</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Daughterty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
<u>493X</u> Immediate cause (a) <u>Pneumonia</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		<u>3 days</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John M. D.</u>		DATE SIGNED <u>10/4/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>10/6/55</u>
NAME OF CEMETERY OR CREMATORY <u>Eastern Shore State Hospital</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Oct. 6, 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>Lecompte Funeral Service Cambridge, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 7 1955

BUREAU V. S.

9709

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Cambridge R.F.D.1</u>		<u>46 years</u>		TOWN <u>Cambridge R.F.D.1</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.1</u>				STREET ADDRESS (If rural give location) <u>R.F.D.1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>William Frederick Hoge</u>				OF DEATH: <u>Oct. 4, 1955</u> 19			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 19, 1876</u>	<u>79</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Farmer self employed</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Lake Minnisoto, Minn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>William F. Hoge</u>				14. MOTHER'S MAIDEN NAME: <u>Eliza Fischer</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FORCEST (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY No. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Marcia J. Hoge, R.F.D.1 Cambridge, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>581.0 Cirrhosis of the liver</u>						<u>6 mos.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>8 yrs</u>	
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/3</u> , to <u>10/4</u> , that I last saw the deceased alive on <u>10/3</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John G. Bunker</u>				DATE SIGNED <u>10/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 6, 1955</u>		REGISTRAR'S SIGNATURE <u>John G. Bunker, R.D.</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

OCT 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9637  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 9 Film 187 10-18-55 et  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09710  
 Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 Park Lane</u>				STREET ADDRESS (If rural, give location) <u>29 Park Lane</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>EMMA</u>		<u>JEAN</u>		<u>HOOPER</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		4. DATE OF DEATH <u>Oct. 4, 19 55</u>	
8. DATE OF BIRTH: <u>June 15, 1888</u>		9. AGE last birthday: <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>George Travers</u>		14. MOTHER'S MAIDEN NAME: <u>Lizzie Travers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Outie Cornish: Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>Instant</u>
<u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John M. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>10-11-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 7, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Beechwith Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorchester Md.</u>	
DATE REC'D BY LOCAL REG. <u>Oct 7 1955</u>		REGISTRAR'S SIGNATURE <u>John M. ...</u>		24. FUNERAL DIRECTOR <u>Herbert M. Stclair</u> ADDRESS <u>Cambridge, Md.</u>			

BUREAU V. S.

NOT 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9698 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09712 Reg. Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				No. 116	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4 Slacum Street</u>			STREET ADDRESS (If rural, give location) <u>4 Slacum Street</u>		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) <u>PHILLIP</u> (Middle) <u>ROBERT</u> (Last) <u>MACK</u>			(Month) <u>Oct.</u> (Day) <u>17,</u> (Year) <u>19 55</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days Hours Min.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>Apr. 19, 1955</u>	<u>5</u> yrs. <u>30</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Charles Phillip Green</u>			14. MOTHER'S MAIDEN NAME: <u>Katherine Mack</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Katherine Mack Cambridge, Maryland</u>	
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>527.2</u> Immediate cause (a) <u>Toxemia</u> DUE TO					<u>1 day</u>
Antecedent cause(s) (b) <u>Acute Respiratory infection</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					<u>1 day</u>
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
<u>2</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Oct. 18 '55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 19 '55</u>		<u>Dorchester Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Oct. 18, 1955</u>		<u>Herbert M. St. Clair</u>		<u>Cambridge, Maryland</u>	
<u>40452742M</u>					

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OCT 20 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

09713

Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Elliotts</u>				STREET ADDRESS (If rural, give location)		/	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fishing Bay</u>							
3. NAME OF DECEASED: (Type or Print)		(First) <u>Ira</u>		(Middle) <u>Fulton</u>		(Last) <u>McCready</u>	
4. DATE OF DEATH		(Month) <u>Oct.</u>		(Day) <u>28</u>		(Year) <u>19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>May 16, 1884</u>	
9. AGE last birthday: <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Boat</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Wise McCready</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Dayton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Sarah McCready, Elliotts, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>975X</u> Immediate cause (a) <u>Drowning</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> DUE TO stating underlying cause last (c)						Instant	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Fishing Bay</u>		21c. (City or town) <u>Elliott,</u> (County) <u>Dorchester</u> (State) <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Oct. 28 '55 9A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Suicide. Jumped in Fishing Bay.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>JAMES M. J.</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED! <u>Oct. 31 '55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 30 '55</u>		NAME OF CEMETERY OR CREMATORY <u>Elliotts Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elliotts, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct 29, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. D.</u>		24. FUNERAL DIRECTOR <u>Ruth S. Willoughby</u>		ADDRESS <u>East New Market Maryland</u>	

BUREAU V. S.

NOV 1 1955

RECEIVED



9699  
CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Dorchester</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Dor.</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>13 Cambridge</b>	LENGTH OF STAY <b>3 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN Vienna, Md. R.F.D.</b>	<b>X</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>67 Cambridge-Maryland Hospital</b>		STREET ADDRESS <b>Rural</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
<b>(First) Addie (Middle) Jones (Last) Oliphant</b>		<b>(Month) (Day) (Year)</b> <b>Oct. 12, 1955 19</b>	
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>Mar. 11, 1915</b>
9. AGE last birthday:		10. CITIZEN OF WHAT COUNTRY?	
<b>40 yrs.</b>		<b>U.S.</b>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY:	
		<b>Church Creek, Md.</b>	
13. FATHER'S NAME: <b>T. Ira Jones</b>		14. MOTHER'S MAIDEN NAME: <b>Frances Saunders</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>NO</b>		17. INFORMANT & ADDRESS: <b>T. Ira Jones, 201 Choptank Ave., Cambridge</b>	

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<b>082 X Immediate cause</b>			
<b>(a) Meningo encephalitis (acute)</b>			
<b>Antecedent cause(s)</b>			
<b>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</b>			
<b>(b) DUE TO</b>			
<b>(c)</b>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY ?	
PLACE (Home, farm, factory, street, office bldg., etc.)		Yes <input type="checkbox"/> No <input type="checkbox"/>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	
22. I hereby certify that I attended the deceased from <b>10/9</b> 19 <b>55</b> , to <b>10/12</b> 19 <b>55</b> , that I last saw the deceased alive on <b>10/12</b> 19 <b>55</b> , and that death occurred at <b>8:00 P.</b> from the causes and on the date stated above.			
SIGNATURE <b>[Signature]</b>		DATE SIGNED <b>10/13/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <b>Oct. 15, 1955</b>		<b>Dorchester Memorial Park</b>	
LOCATION (City, town, or county) (State)		<b>Cambridge, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Oct. 14, 1955</b>		24. FUNERAL DIRECTOR <b>Kenneth R. Thomas, Cambridge, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

OCT 17 1953

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 146

9720

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 TOWN Cambridge</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 TOWN Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67 Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>138 Race Street</u>			
3. NAME OF DECEASED: (First) <u>John</u>		(Middle) <u>Wesley</u>		(Last) <u>Paul</u>		4. DATE OF DEATH: (Month) <u>Oct.</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>June 1, 1868</u>	
9. AGE last birthday: <u>87</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Carpenter retired</u>		11. BIRTHPLACE (State or foreign country): <u>Cambridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Paul</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Reese</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ear Johnson, 138 Race St. Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>420.0</u>		
Immediate cause (a) <u>Cardiac failure</u>		<u>1 day</u>
Antecedent causes (s) (b) <u>Cardiac decompensation</u>		<u>2 wks</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Arteriosclerotic Heart Disease</u>		<u>unknown</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>10/15/55</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 10/15, 1955, to 10/15, 1955, that I last saw the deceased alive on 10/15, 1955, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE Alfred R. Maryanor (Degree or title) M.D. ADDRESS 136 Race St., Cambridge DATE SIGNED 10/17/55

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Oct 17, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct 17 1955</u>	REGISTRAR'S SIGNATURE <u>John Paul</u>	24. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u>	ADDRESS <u>Cambridge, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11399

11915

Reg. Dist.

No. 116

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Dambridge</u>		<u>3 hrs. - 15 min.</u>		TOWN <u>Easton, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>---</u>			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print)		<u>Stella</u>		<u>---</u>		<u>Rash</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>W</u>		<u>M</u>		<u>Nov. 8, 1898 (?)</u>	
9. AGE last birthday:		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>57</u> yrs.		<u>Domestic</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Charles Harris</u>				<u>Emma Willis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service) <u>---</u>		<u>---</u>		<u>Eastern Shore State Hospital Records</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebral embolus</u>						<u>1 day</u>	
DUE TO							
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>						<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>John H. H. H.</u>						<u>12/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 22, 1955</u>		<u>Landing Neck</u>		<u>Talbot Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/30/55</u>		<u>John H. H. H.</u>		<u>Maurice E. Newnam &amp; Son</u>		<u>Easton, Md.</u>	

BUREAU V. S.

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RECEIVED

9711

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cambridge</u>	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lock</u>
TOWN <u>Rural Cambridge</u>	LENGTH OF STAY (in this place) <u>2 yrs 6 mo's</u>	OR TOWN <u>Lock</u>	OR TOWN <u>Lock</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hosp.</u>	STREET ADDRESS (If rural give location) <u>Main St.</u>		

3. NAME OF DECEASED: (Type or Print) <u>James Bowen Richards</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>Oct 2 1955</u>		
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 2, 1897</u>	9. AGE last birthday: <u>58</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Orthopedic Operator, Rema K. K.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>Harry B. Richards</u>		14. MOTHER'S MAIDEN NAME: <u>Hettie Disharoon</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): <u>Yes - World War I</u>		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS: <u>Hospital Records, Cambridge</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>		
ANTECEDENT CAUSE, (S) DUE TO (B) <u>Cerebral Arteriosclerosis</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION: <u>/</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>MARCH 14, 1953</u> , to <u>OCT 2, 1955</u> , that I last saw the deceased alive on <u>OCT 1, 1955</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thomas J. Dudge</u>		ADDRESS <u>M.D. Cambridge</u>	DATE SIGNED <u>OCT 2 55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>Washington</u>	LOCATION (City, town or county) (State) <u>Essex, Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Oct 5, 1955</u>	REGISTRAR'S SIGNATURE <u>John H. D.</u>	24. FUNERAL DIRECTOR <u>Smith &amp; Kelloggby</u>	ADDRESS <u>East New Market, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

OCT 6 1955

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9701

## CERTIFICATE OF DEATH

09717

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Dorchester</b>		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Cambridge</b>		<b>2 weeks</b>		TOWN <b>Cambridge</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge-Maryland Hospital</b>				STREET ADDRESS <b>112 Locust Street</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Edward Allen Robbins</b>				<b>Oct. 27, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>Oct 12, 1898</b>	<b>57</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>Manager County Liquor Stores</b>			<b>Cambridge</b>		<b>Cambridge</b>		<b>U.S.</b>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>William E. Robbins</b>				<b>Helen Henry</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>Yes</b>		<b>U.S.M.C. 1917-1937</b>		<b>112 Locust St., Mrs. Elizabeth R. Robbins, Cambridge, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>420.1 IMMEDIATE CAUSE (A)</b>						<b>10 days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B)</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>14 days</b>	
<b>19a. DATE OF OPERATION</b>						<b>10 days</b>	
<b>19b. MAJOR FINDINGS OF OPERATION</b>						<b>20. AUTOPSY</b>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>						<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>M.</b>		<b>M.</b>					
<b>22. I hereby certify that I attended the deceased from Oct 12, 1955, to Oct 27, 1955, that I last saw the deceased alive on Oct 27, 1955, and that death occurred at 8:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<b>W. H. Thompson, M.D.</b>				<b>Oct 28, 55</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<b>Burial</b>		<b>Oct. 29, 1955</b>		<b>Christ Church Cemetery</b>		<b>Cambridge, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE Oct. 24, 1955</b>		<b>John H. D.</b>		<b>Kenneth R. Thomas</b>		<b>Cambridge, Md.</b>	

U.S. A. OVERSEA

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09718

9712

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Woolford</u>		<u>10yrs</u>		TOWN <u>Woolford</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>none</u>				<u>none</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Carrie Harrington Robinson</u>				<u>10 21 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>f</u>	<u>W</u>	<u>Widow</u>	<u>Nov. 11, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Madison, Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel P Harrington</u>				<u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Mrs Claude Brooks Woolford Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis, generalized</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				INTERVAL BETWEEN ONSET AND DEATH			
STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>4 days</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/17</u> , 19 <u>55</u> , to <u>10/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>55</u> , and that death occurred at <u>7:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>Lawrence Maryanov</u> M.D.				<u>Cambridge Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/23/55</u>		<u>Old Trinity</u>		<u>Dorchester Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 23, 1955</u>		<u>John H. Hare, R.D.</u>		<u>Le Compte's Funerl Service</u>		<u>Cambridge</u>	



9713

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>Cambridge R.F.D.3</u>	LENGTH OF STAY (in this place) <u>30 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge R.F.D.3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 Rural</u>		STREET ADDRESS (If rural give location) <u>Rural</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Joseph S. Schaffner</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 12, 1955</u> <u>19</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Apr. 13, 1862</u>
9. AGE last birthday <u>93</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Coal Dealer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Schaffner</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Frank L. Schaffner, Cambridge R.F.D.3</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>153X</u>		<u>Starrateon</u>	
ANTECEDENT CAUSE (S):		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Intestinal Obstruction</u>	
		DUE TO	
		(C) <u>Carcinoma of the Colon</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>Arterio-sclerosis generalis</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> , to <u>Oct. 12, 1955</u> , that I last saw the deceased alive on <u>Oct. 12, 1955</u> , and that death occurred at <u>12.10 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>James L. Thompson</u>		ADDRESS <u>M. D. Cambridge, Md.</u>	
DATE SIGNED/ <u>Oct. 13, 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>John Hall, Jr. M.D.</u>	
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



10-1-35

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC HEALTH

Division of Field Operations

Office of the Assistant Secretary for Public Health

Office of the Assistant Secretary for Public Health

Office of the Assistant Secretary for Public Health

Office of the Assistant Secretary for Public Health

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Office of the Assistant Secretary for Public Health

BUREAU V. 8

OCT 17 1955

RECEIVED



9714

## CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<b>X</b> <b>Hurlock - Rural</b>		<b>Life</b>		<b>Hurlock - Rural</b>		<b>X</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Bobtown</b>				<b>Bobtown</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>Ephriam Smith</b>				<b>October 2, 1955</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>Male</b>		<b>Colored</b>		<b>Widowed</b>		<b>About 1876</b>	
9. AGE last birthday		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>About 79 yrs.</b>		<b>Day Laborer</b>		<b>Farm</b>		<b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		15. MEDICAL CERTIFICATION	
<b>U.S.A.</b>		<b>Henry Smith</b>		<b>Rebecca (maiden name unknown)</b>		16. INTERVAL BETWEEN ONSET AND DEATH	
17. INFORMANT & ADDRESS:		18. SOCIAL SECURITY NO.		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Delsia Holliday, Hurlock, Md., R.F.D.</b>		<b>Unknown</b>		<b>No</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				21. TIME (Month) (Day) (Year) (Hour) OF INJURY			
IMMEDIATE CAUSE				21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
ANTECEDENT CAUSE (S):				21F. HOW DID INJURY OCCUR?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Chronic Myocardial Degeneration</b>							
(B) <b>Arteriosclerosis</b>							
(C) <b>Senile Psychosis</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				22. I hereby certify that I attended the deceased from <b>October 1, 1955</b> , to <b>October 2, 1955</b> that I last saw the deceased alive on <b>October 1, 1955</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
				21F. HOW DID INJURY OCCUR?			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				24. FUNERAL DIRECTOR ADDRESS			
<b>Burial</b>				<b>J.J. Framptom and Son, Federalsburg, Md.</b>			
DATE REC'D BY LOCAL REGISTRAR				25. DATE SIGNED			
<b>Oct. 6 - 1955</b>				<b>10/2/55</b>			
REGISTRAR'S SIGNATURE				26. DATE SIGNED			
<b>Charles W. Hastings</b>				<b>10/2/55</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 21 1955

RECEIVED

9715

## CERTIFICATE OF DEATH

Reg. Dist. No. 119

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Federalsburg - Rural</u>		<u>Life</u>		X <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eldorado Road</u>				STREET ADDRESS (If rural give location) <u>Eldorado Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Boyd Hardesty Speorl</u>				OF DEATH: <u>October 6 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Nov. 14, 1897</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Day Laborer</u>		<u>Farm</u>		<u>Dorchester Co., Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Henry C. Speorl</u>				<u>R. Matilda Figg</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
3 <u>No</u> (If Yes, give war or dates of service)		<u>213-09-8503</u>		<u>Mrs. Ralph J. Trice, Federalsburg, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S): (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>1927</u> , 19 <u>  </u> , to <u>10-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>55</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Leman</u>		ADDRESS <u>Federalsburg</u>		DATE SIGNED <u>Nov 10-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 9, 1955</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct 9-1955</u>		<u>Charles Hastings</u>		<u>J.J. Frampton and Son</u>		<u>Federalsburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

OCT 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9702

09722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<u>13</u> TOWN <u>Cambridge</u>		<u>X</u>		TOWN <u>Cambridge RFD # 2</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Acadmev &amp; Muse Sts</u>				STREET ADDRESS (If rural, give location) <u>RFD# 2</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH:</b> (Month) (Day) (Year)			
<u>Phillip R Stephenson</u>				<u>Oct 27 19 55</u>			
<b>5. SEX:</b>		<b>6. COLOR OR RACE:</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b>		<b>8. DATE OF BIRTH:</b>	
<u>M</u>		<u>W</u>		<u>Married</u>		<u>7/11/1893</u>	
				<b>9. AGE last birthday:</b>		<b>10. IF UNDER 1 YEAR</b>	
				<u>62</u> yrs.		<u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):</b> <u>US Wild Life</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Fish Culturalist</u>		<b>11. BIRTHPLACE (State or foreign country):</b> <u>Scranton. PA.</u>	
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>Eli Stephenson</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Mary Binkley</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>World War I</u>				<b>16. SOCIAL SECURITY No.:</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Cambridge RFD #2</u>	
						<u>Mrs Isabelle Stephenson</u>	

<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
<u>420.1</u> <b>Immediate cause</b> (a) <u>Coronary occlusion</u> <b>DUE TO</b>						<u>few min.</u>	
<b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDING OF OPERATION:</b>			
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)</b>		<b>21c. (City or town)</b>		<b>(County)</b>	
						<b>(State)</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <u>John M. [Signature]</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>Oct. 31, 1955</u>			
				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
				<b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<u>Burial</u>		<u>10/30/55</u>		<u>Dorchester Memorial PK</u>		<u>Cambridge Md.</u>	
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>	
<u>Oct. 30, 1955</u>		<u>John M. [Signature]</u>		<u>Le Compte Funeral Service</u>		<u>Cambridge,</u>	

10013

10013

RECEIVED BY BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

BUREAU V. S.

NOV 1 1955

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9703

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>50</u> yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge,</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>403 Acadmey St</u>				STREET ADDRESS (If rural give location) <u>403 Acadmey</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Charles</u> <u>B</u> <u>Todd</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>25</u> <u>19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 25 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Waterman</u>		11. BIRTHPLACE (State or foreign country): <u>Crochern</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Todd</u>				14. MOTHER'S MAIDEN NAME: <u>Melivena Bramble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>214-20-0860</u>		17. INFORMANT & ADDRESS: <u>Mr Insley Todd Cambridge</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>161X</u>						<u>11 months</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Carcinoma of larynx</u> DUE TO							
(B) _____ DUE TO							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>May 20 1955</u>		19B. MAJOR FINDINGS OF OPERATION <u>Carcinoma larynx</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20/54</u> to <u>10/25</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>54</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M. D. <u>Cambridge Md</u>		DATE SIGNED <u>10/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Pk</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 27 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Le Compte Funeral Service</u>		ADDRESS <u>Cambridge</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



UREAU V. S.

NOV 2 1955

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9716				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		09725 Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Dorchester		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		TOWN		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Choptank River		STREET ADDRESS		107 Willis Street	
3. NAME OF DECEASED:		(First) Dorothy		(Middle) Burton		(Last) Todd	
4. DATE OF DEATH		(Month) Oct. 16, 1955		(Day) 19		(Year) 19	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Married		Jan. 25, 1912	
9. AGE last birthday:		43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		Housewife	
11. BIRTHPLACE (State or foreign country):		Golden Hill, Md.		12. CITIZEN OF WHAT COUNTRY?		U.S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John S. Burton				Gertrude Ruark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		No		16. SOCIAL SECURITY No.:		220-10-6182	
17. INFORMANT & ADDRESS:		Camp Pendleton, California					
		Sgt. Ronald E. Todd, U.S.M.C.					
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... Accidental drowning						Instant	
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause (c).....							
stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
river		Nr. Cambridge Dor. Md.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
10-15-55 ? M.				Fell from boat.		07	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
John M. M. J.		Oct. 19, 1955		Dorchester Memorial Park		Cambridge, Md.	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR		ADDRESS	
Burial		Oct. 18, 1955		Kenneth R. Thomas, Cambridge, Md.			

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OCT 20 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please, write the causes of death clearly and legibly.

9717				09726			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Choptank River</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Choptank River</u>				STREET ADDRESS (If rural, give location) <u>107 Willis St.</u>			
3. NAME OF DECEASED: (First) <u>Woodrow</u>		(Middle) <u>Wilson</u>		(Last) <u>Todd</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 16, 1955</u> <u>19</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 8, 1913</u>	
9. AGE last birthday: <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Traveling Salesman for Hardware Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Toddville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Charles M. Todd</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Mills</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>214-07-8365</u>		17. INFORMANT & ADDRESS: <u>Camp Pendleton, California</u> <u>Sgt. Ronald E. Todd, U.S.M.C.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Accidental drowning</u>							
DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>10-15-55</u>				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>river</u>		21c. (City or town) (County) (State) <u>Nr. Cambridge Dor. Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10-15-55</u> <u>?</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell from boat</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/18/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 19, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Oct. 18, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

BUREAU V. S.

OCT 20 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

9734

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>40 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u> <u>102 Franklin Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Henrietta Moore Gootee Willey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>9</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>10/9/55</u> ✓
9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Lakesville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Henry M. Moore</u>	
14. MOTHER'S MAIDEN NAME: <u>Zora Mc Namara</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or unk.): <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Claude S. Gootee Jr., 102 Franklin St., Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u>			
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Corruption heart of failure</u> DUE TO			<u>7 days</u>
(B) <u>Coronary thrombosis</u> DUE TO			<u>7 days</u>
(C) <u>Anticoagulation given</u>			<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia</u>			<u>7 days</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Aug</u> , 19 <u>55</u> , to <u>Oct 9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Oct 9</u> , 19 <u>55</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James W. Thompson</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE SIGNED <u>Oct 10 '55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/12/55.</u>	
NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetary</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 12, 1955</u>		REGISTRAR'S SIGNATURE <u>John Hall, R. D.</u>	
24. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. 2

OCT 14 1955

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